

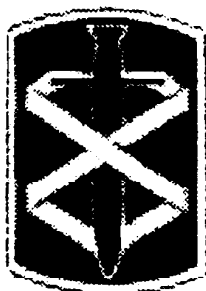
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**18th Medical Command
Special Issue**

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JOURNAL

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A Professional Bulletin for the AMEDD Community

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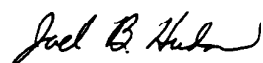
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Perspective

The AMEDD in Korea

This Nation's commitment to our allies lives daily through our presence in Korea. It represents Army and national values at work. For more than 40 years our AMEDD has rotated individually in and out of Korea in 1 and 2 year tours dedicated to supporting our coalition partners in an armistice that has endured and in our dedicated support to soldiers and their families at home and abroad. This issue of our AMEDD Journal highlights that commitment and reminds us of why!

The U.S. has remained firm in its commitment to the Republic of Korea (ROK) since the cessation of hostilities in Korea in 1953. Currently, 37,000 soldiers along with their families and numerous other civilians reside throughout the South Korean peninsula. Providing high quality care in a timely manner with the resources available has proven to be a formidable task. This issue of the AMEDD Journal provides numerous insights into the peacetime mission of the AMEDD in this remote theater.

The military threat from North Korea is ever-present and a conflict could erupt anytime. The added responsibility of AMEDD units in the ROK is to constantly prepare for the treatment and evacuation of both civilian and military casualties. Regular field exercises for medical units from the 121st General Hospital to forward medical companies along the demilitarized zone help to maintain this readiness. More than just the treatment of casualties, medical logistics and transportation are equally important in the maintenance of healthcare assets.

This issue of the AMEDD Journal devotes itself to exploring many of these diverse and different challenges in the ROK. These articles provide insight into the important role of the AMEDD in its continued readiness mission *to conserve the fighting strength*.

- *No Medical Task Force Smiths*. Task Force Smith was the U.S. Army's initial and highly unsuccessful attempt to stop the invasion of the ROK in 1950. The well-

trained North Korean Army easily defeated the hastily arranged and untrained task force. This article discusses the role of the 121st Evacuation

Hospital in both delivery of peacetime healthcare and preparations for a potential conflict in the Korean peninsula.



Major General James B. Peake

- *Why U.S. Forces are in Korea – A Historical Overview*. Explains the historical mission of the U.S. in defense of the ROK and emphasizes its continued role in maintaining stability in the region. This is essential information for all soldiers, whether assigned to Korea or not.

- *18th MEDCOM's Ambulatory Care Directorate*. The 18th MEDCOM is the lead AMEDD organization in the ROK and is charged with the delivery of healthcare in the peninsula. Summarizes the role of a newly formed organization to unify the AMEDD mission to deliver quality healthcare, provide training, and enhance readiness.

- *WHNS for Medical Forces in the ROK*. Describes the role of Wartime Host Nation Support (WHNS) in the provision of medical care in the ROK. The WHNS is a crucial element in the AMEDD's ability to provide timely casualty care during a crisis.

- *Garrison Medicine with a Field Medical Unit*. Provides insight into the unique role of the 168th Medical Battalion in delivering area medical support to 10 U.S. Army camps.

- *163rd Institutes OCONUS Extension of the TRICARE Family Member Dental Plan*. Explains the challenge of providing dental care in the ROK and how

interactions with local dentists helped to establish a long-term relationship.

- *Korean War Odyssey: Return to Hill 303.* Reminds us of the pitted battle the U.S. Army fought in 1950 against the North Korean forces at Hill 303, near the town of Wacgwan.

- *The 121st General Hospital – Leading Edge of Forward Deployed Forces; 18th MEDCOM Facilitates High Quality Care in Korean Hospital;*

Protecting the Force: New Technology for Military Food Inspection; Are You Prepared for the Unexpected? Each provides a unique snapshot of the key medical units and responsibilities in Korea. Although each unit has a particular mission, together they help form the backbone of the AMEDD presence in the ROK.

This is our AMEDD - deployed around the world, serving our Nation, its soldiers and their families. It is heritage rich, values based, . . . "Caring beyond the call of duty."

AMEDD Journal Clinical Manuscript Competition

The AMEDD Journal Editorial Board is pleased to announce the "2000 AMEDD Journal Clinical Manuscript Competition." The Board is soliciting clinical manuscripts that conform to the guidelines listed on the inside back cover of this AMEDD Journal issue. The Board will judge all manuscripts received by 1 September 2000 for subject analysis, clarity, organization, and writing style. There will be appropriate recognition for the best manuscripts and as many as possible will be published in the October - December 2000 issue of the Journal. Please direct any questions to COL James M. Lamiell, Chairman, Editorial Board, DSN 471-2511, (Comm 210/221-2511) or at **James.Lamiell@amedd.army.mil**.

The U.S. Army Medical Department Journal has been notified by the Air University, Maxwell Air Force Base, FL, that it has been selected for indexing by the Air University Index to Military Periodicals. The Army Medical Department Center and School's Stimson Library staff will provide the indexing of the Journal.

The Air University Index is a standard subject and author index to significant articles, news items, and editorials from English language military and aeronautical periodicals. The Index is widely available in military and civilian libraries worldwide and also can be accessed at: <http://www.dtic.mil/search97bin/aulimp/search> or <http://www.au.af.mil/au/aul/muir1/aulimp1.htm>.

No Medical Task Force Smiths

COL James Kirkpatrick, MC†
LTC Maureen Coleman, MS††

Back Down the Ridge

Say today one of our platoons takes a hill: the high crest of this wave of wounded thunders into the nearest Battalion Aid Station before the boys on top of the ridge have finished digging in.

From now on, it is like widening circles of ripples on a pond. Within an hour or so this wave of wounded, its crest not quite so sharp, rolls into MASH. About 72 hours later they feel the wave, a little flatter now, in Tokyo Army Hospital. A couple of weeks later, the first of them reach Letterman in San Francisco. In still another week this wave of wounded from that particular ridge, even more flattened out but still a rise in the case-load, has reached East Coast Army hospitals like Walter Reed and Murphy. So the nurses on the wards who have had Korean duty, when they see the beds begin to fill up, wonder which particular ridge it was. And why we needed it.

'Back Down the Ridge' by W.L. White

June 25, 1950, Beginning of the Korean War

At about 3:30 on Sunday morning (25 June 1950), Captain Joseph R. Darrigo was jarred awake by the crash of artillery fire. ...It was heavy, continuous, and alarming.

Darrigo grabbed his shirt and shoes and jumped into his jeep, his Korean houseboy on his heels. Still shirtless and shoeless, he drove the jeep down twisting, dusty roads, south toward downtown Kaesong. In the middle of town at a traffic circle he stopped suddenly, mouth agape. Pulling into the railroad station was a 15-car North Korean train, jammed with infantry-some hanging on the sides.

The train-and the large numbers of North Korean People's Army soldiers-was proof to Darrigo that this was no "rice raid" or minor border incident. It was obviously a meticulously planned, highly professional military attack, the real thing. And like Pearl Harbor, he thought, it had come on a Sunday morning without warning.

From "The Forgotten War," by Clay Blair

This year, June 25th commemorates the 50th anniversary of the beginning of the Korean War. The end of that war has not yet come. As we have in every war in U.S. history, the Army Medical Department (AMEDD) served at the side of soldiers; moving them to safety, saving their lives, healing their wounds, and keeping them fit to fight. From that first day when no Army hospitals were present on the peninsula, the AMEDD projected a capable medical force able to support the needs of a huge Army for evacuation, hospitalization, prevention, and medical supply. The U.S. Army units, like those comprising **Task Force Smith**, underestimated the strength and determination of the enemy. Fifty years ago the U.S. Army was not prepared, nor resourced to fight. The AMEDD was also challenged to support the Korean War. We must not forget the bitter lessons learned 50 years ago.

Several of the units that came to the original Korean conflict remain on the peninsula. They remain here for the simple reason that the war they came to support is not over. In fact, it can resume at any time the North Koreans want it to resume.

Which are those units from the original Korean War? The 121st Evacuation Hospital, Semimobile, is represented by the 121st General Hospital, the 163rd Medical Battalion (Separate) recently folded its flag in

order to activate the 618th Dental Company (Area Support). The 618th Medical Clearing Company (Separate) served in 1950 on the peninsula. The 38th Malaria Control Detachment remains as the 38th Medical Detachment (Preventive Medicine). The 52nd Medical Battalion (Separate) is represented by the 52nd Medical Evacuation Battalion along with the 560th Medical Ambulance Company.

These units represent 50 years of military medical history, a history of tough battles fought and hard lessons learned. The current commanders and soldiers owe a great debt to those who came here first. Our way of carrying that debt is through remembering the lessons they learned with so much struggle. This is one small way we can honor the days and nights our predecessors spent in the artillery-shaved moonscape of a war-torn country. Out of the ashes has risen a modern country with a standard of living that the ghosts of 1950 would not recognize. Fighting a brutal war is replaced with maintaining an armistice to ensure the survival of a self-reliant Republic of Korea.

Although modern South Korea would be unrecognizable to the veterans of 1950-53, the potential for renewed conflict with North Korea is the unchanged reality from the past. The long ominous shadow of a land at armistice, but not peace, is a daily reminder that with no notice and at a time of the enemy's choosing, the heirs of those same BDU-wearing, dirty boots modification table of organization and equipment (MTOE) medical units could be thrust back in time to 1950. And, at that moment, unpredictable though it is, the expectation, no, the demand will be that those units perform to the same high standard they achieved in the 1950s. There must never be a Medical Task Force Smith.

To avoid the medical version of a Task Force Smith, we must strike a balance every day between providing the armistice healthcare benefit and the training regimens required for wartime combat health support. To be sure, the same overlapping missions and the same need for balance are true for the entire AMEDD, but the issue is starkly visible in Korea. It would be ideal if we could isolate the two missions. But the luxury of having one medical force structure for peacetime healthcare and another separate force for war is neither realistic nor

affordable. Even if it were possible, would it be the right approach? Is the requirement to do both missions a detriment? Only if we let it be. In Korea, every unit performs both missions. In many cases, in carrying out their peacetime healthcare mission, units and soldiers practice their wartime mission. The 52nd Evacuation Battalion units transport patients throughout the peninsula, using their wartime equipment and tactics, techniques, and procedures on a daily basis. The Veterinary Detachments, Preventive Medicine Detachments, and the 168th Area Support Medical Battalion serve a beneficiary population yet function in many of their wartime locations doing essentially their wartime mission. To a large degree, the distinction between armistice/administrative and wartime/tactical is irrelevant in Korea.

For example, there is no Medical Department Activity (MEDDAC) in Korea; however, there is the 121st General Hospital. Since it has a building, clinics, dining facility, Red Cross volunteers, a Women and Infants Care Unit, a Joint Commission on Accreditation of Healthcare Organization Commendation, and all the features of a stateside community hospital, the 121st is assumed to be a MEDDAC; it is not. It is something much more. The 121st is a Medical Force 2000 DEPMEDS General Hospital, equipped and trained to field a 476-bed surgical-heavy tactical facility anywhere it is needed. The 121st is, of course, also the community hospital for Seoul and the referral hospital for all U.S. Forces in Korea; however, that is only a part of its capability and those functions are similarly aligned with the functions that a DEPMEDS hospital must perform in war.

Although staffed at less than 50% of its wartime strength, this forward-deployed DEPMEDS-equipped hospital prepares to transition to war by training with its own wartime equipment in its fixed facility, as well as conducting a full schedule of mission-essential task list (METL)-related individual and collective field training. With the unit staffed as thinly as it is, the 121st, like all 18th Medical Command (MEDCOM) units, has reached out to train the designated professional fillers (PROFIS)—no matter where they are assigned—that bring the hospital to full staffing.

A key element in assuring no Medical Task Force

Smiths is avoiding the mistakes that created the original Task Force Smith. That sad, ragtag outfit, a unit in name only, brought innumerable difficulties to its task—all made even more challenging by the fact that the outfit had been organized on the fly. None of the soldiers knew their leaders and few, if any, of the leaders had trained together. A major benefit to operating the AMEDD system in Korea as an MTOE structure is the avoidance of that key mistake. Since 18th MEDCOM is already here in its wartime configuration, no reorganization is required upon commencement of hostilities. Imagine if a MEDDAC were alerted to go to war; there are no tactical vehicles, no tactical communications, and very little nuclear, biological, and chemical defense equipment. But, most importantly, the organization would require a complete shuffle in order to deploy and operate.

Let us not overlook how difficult the transition to hostilities would be, even for the 18th MEDCOM. Almost without exception, units would be required to move to new locations and accept augmentees, both PROFIS and nonmedical. Movement to a new area of operations is a METL task for all units. At least we can reconnoiter our destinations, if not train on them. Assuring that units are ready to accept augmentation, requires more creativity. The reduced Authorized Level of Organization of the 18th MEDCOM makes our units reliant on augmentation to expand to their full strength. This, in turn, places responsibility on Commanders worldwide to ensure the wartime readiness of the officers and enlisted PROFIS who, with short notice, will arrive on the Korean peninsula. The Commanding General, Tripler Army Medical Center, and the Commander, 18th MEDCOM, along with key subordinate Commanders, such as the 121st General Hospital Commander, have aggressively pursued training opportunities both on and off the peninsula.

A series of exercises takes place in South Korea and in Hawaii to prepare the PROFIS personnel for their wartime mission. Operation "Pacific Warrior" took place 4-22 November 1999, at Schofield Barracks field-training area. The exercise was designed to enhance individual and organizational readiness to respond during emergency deployments within the Pacific Region. It was a comprehensive training event that used a Korean peninsula scenario and integrated reserve and active components.

Live surgeries, tactical force protection training, and nuclear, biological, and chemical casualty management and training were planned for and executed. This exercise integrated the battle staff of the 121st General Hospital with key and experienced leaders from Tripler Army Medical Center to provide vital training to not only PROFIS, but also multi-component medical elements. Both Naval and Air Force units reported that valuable lessons concerning interoperability with Army elements were gained by their participation in "Pacific Warrior."

Additionally, throughout the year, PROFIS are deployed from continental United States to train on the Korean peninsula with their parent unit. Joint exercises are used in order to leverage dollars and resources, such as the cost of air transport for exercise personnel. Strangely, because of the rapid turnover in Korea and because PROFIS personnel typically stay at their duty station for several years, often the PROFIS are the continuity for the parent unit in Korea.

Integration of PROFIS and other augmentees is a battle task for all medical units in Korea. Preparing for many of the elements of that task can be accomplished in Korea: billeting, feeding, transportation, equipping, etc. What cannot be done from here is ensuring the individual skills of the augmentees. The individual training that Commanders worldwide conduct to support this task is a priceless element of the readiness of medical units in the Republic of Korea. As much as the costs are borne by decrements in productivity in the Stateside MEDDACs and MEDCENs, the payoff is realized in Korea when PROFIS arrive with the necessary individual skills to survive and be effective in the field.

Commanders at all medical treatment facilities must insure that all officers, noncommissioned officers, and soldiers are trained in patient decontamination and common task training. This is vital to success in this theatre. Units stationed here are depending on PROFIS coming into theatre prepared to execute a smooth transition to war. The Commanders of the MEDDACs and MEDCENs are the keys to the success and survival of their soldiers who come as medical augmentees to this theatre in time of war.

The soldiers and leaders of 18th MEDCOM are the

grateful heirs of a generation of medics of the past. They have willed to us the traditions and history of the units that came here first in 1950. Ensuring that the units that make up that legacy are prepared for war is the best way to honor the noble medics who sacrificed so much, for so many, 50 years ago. We honor them best by making sure that there never will be a Medical Task Force Smith.

The past is never dead. It's not even past.
From "Requiem for a Nun" by William Faulkner

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Why U.S. Forces are in Korea – A Historical Overview

LTC Steven H. Carpenter, MS†

In the early morning hours of 25 June 1950, North Korea embarked upon an invasion of South Korea. Shortly before the invasion, U.S. forces completed their withdrawal from the peninsula and left a severely outnumbered and outgunned South Korean Constabulary force to tend to the defense of the Republic of Korea (ROK). The Soviets and the North Koreans miscalculated America's resolve to oppose them if they sought reunification of the Korean peninsula through armed conflict. After a 3-year war that cost more than 142,000 American battle casualties, a cease-fire was signed at Panmunjom on 27 July 1953, which technically ended active combat operations. American military leaders were assigned the task of nation building but lacked clear guidance and leaders with the requisite skills to perform such a monumental task immediately following World War II (WWII). Policy-makers in Washington DC failed to understand the importance the Korean peninsula would play in the balance of power in Asia early on. An appreciation of Korea's geopolitical picture, significant events in its history, and the circumstances immediately following WWII prior to the Korean War is helpful in understanding how American policy was formulated immediately following WWII and why American forces maintain guard of the Korean peninsula today. The strategic importance of the peninsula and the hard learned lessons, which led to the Korean War, are important to understand and remember if we are to prevent history from repeating itself.

The date of 25 June 2000 marks the 50th anniversary of the early morning invasion of the ROK by the North Korean People's Army under General Chai Ung Jun with seven assault infantry divisions, a tank brigade, and two independent infantry regiments. President Truman's immediate decision to commit forces in support of South Korea along with United Nations Command forces

abruptly changed the course of North Korean intentions. After a 3-year war that cost more than 142,000 American battle casualties, a cease-fire was signed at Panmunjom on 27 July 1953, which technically ended active combat operations. However, tensions between the two governments separated by the 38th parallel have remained high on the Korean peninsula even up to the present day period. President Bill Clinton said at the Korean National Assembly in July 1993, "The Korean peninsula remains a vital American interest." As proof of U.S. resolve, almost a half century after it was decimated at Kunu-ri protecting Eighth U.S. Army's withdrawal from North Korea, the 2nd U.S. Infantry Division currently sits astride the Seoul invasion corridor as a tripwire guaranteeing certain U.S. involvement in any future conflict there. In view of the importance of the ROK to U.S. interests and America's resolve to forward deploy a military deterrent, it is essential to understand the geopolitical aspects of our involvement here. This article seeks to provide a historical overview of the circumstances leading to the invasion of the ROK in June 1950. Geography, politics, diametric ideologies, political unrest among the Korean people, and failures by the U.S. to develop coherent foreign policy immediately following the end of WWII, all contributed to the misjudgments of North Korea in a 3-year tragedy known as the "Forgotten War."

The Korean Peninsula's Geopolitical Picture

The geography of the Korean peninsula places it in a strategically significant location. From the very beginning of recorded history, war and tragedy have been the main themes of Korea's past. Korea is flanked by three major powers: China, Japan, and Russia. In the northernmost part of the Korean peninsula, a river-mountain complex separates Korea from Manchuria and the Maritime Provinces of the former USSR. To the east across the Sea

of Japan, the Japanese islands flank the peninsula. To the west, the Yellow Sea forms an ocean bridge between Korea and China. Korea has been described as a “dagger pointed at the heart of Japan” and as a gateway leading into Asia. For China, and later Russia, Korea was a back door which needed to be guarded against intruders and to be opened when it could contribute to growth and expansion. Korea’s ice-free ports on the Sea of Japan were highly coveted by Russia. Korea has seldom been free of domination from any one of these three superpowers and suffered immeasurably throughout history as a battleground from which ruthless conquerors ravaged Korea’s resources: the land and its people.

Under Mongol domination in the 13th century and into the early 14th, Korea served as a staging area for two aborted attempts by Kublai Khan for invasions of Japan from Korea. By the mid-14th century, Mongol influence dissipated and Korea began to flourish through adaptation of a Chinese culture, which brought Korea to a level of civilization that rivaled that of China. By 1592, Japanese samurai pillaged the peninsula for 7 years. With the aid of China, Korea was able to expel their Japanese conquerors but not until the country had become a wasteland and the best of its artisans and scholars had been exported to Japan. By the 19th century, Japan, Russia, and China wrestled for control of the Korean peninsula.

Japanese Conquest and the Flames of Korean Nationalism

Japan ultimately assumed control of Korea by defeating China and Russia in short decisive wars using western military techniques. Having already savagely and mercilessly seized complete control of Korea by 1907, Japan formally annexed Korea in August 1910. Under the 35 years of Japanese rule, Korea’s land and people were exploited. Japanese colonization of Korea was a period of development and modernization, mainly for military purposes. The Japanese took over management of Korean businesses. They established new industries under Japanese control and the government directed much of the land, selling it to Japanese settlers. During Japan’s conquest of Asia in the 1930s, goods manufactured in Korean factories were used exclusively for military purposes. During WWII, the Japanese maltreated the Korean people and the natural resources to their own

advantage causing widespread resentment, sporadic uprisings, and nationalistic aspirations among the Korean people. The flames of patriotism and nationalism under harsh Japanese rule fostered the development of Korean revolutionary groups which sought to defy their foreign conquerors whenever possible. The presence and sustainment of these revolutionary groups would later serve as the foundations for provisional governments for the Korean peninsula at the conclusion of WWII when the country was to be divided between the allies after the defeat of Japan.

On 1 March 1919, a revolutionary group calling itself the “Provisional Government of the Republic of Great Korea” read a declaration of independence before a student gathering in Seoul. The Japanese government was infuriated by this action and sought to hunt down the instigators. Fearing torture and death, members of the group fled to Shanghai and established a provisional government. Doctor Syngman Rhee headed the group as its Premier. The government later moved to Nanking and soon thereafter to Chungking. Rhee later moved to the U.S. in the mid-1930s, having obtained a significant following, and became much revered by the Korean people for his efforts to establish an independent Korean government.

A strong Korean Communist Party emerged in Korea in 1925, which served to push the well-organized and well-led underground movement against Japan. Although the Korean communists had ties to Russian communists, the Russians did not encourage the Koreans. It was believed there was a secret agreement between Russia and Japan. Many Korean communists took refuge from the Japanese by settling in Manchuria, Russia, and China. One communist leader, Kim Il Sung who was born near Pyongyang, Korea, moved to China during his boyhood where he joined the Communist Party. During the 1930s and early 1940s, he led Korean guerrilla forces against the Japanese in Korea.

Japanese Surrender and the Dividing of Korea

The demise of the Axis at the conclusion of WWII exacerbated the political and policy differences between Russia and the U.S. The future of the Korean peninsula was one of many countries in Asia and Europe affected by these differences. Until the end of WWII, the U.S.

remained mostly indifferent to developments on the peninsula. The U.S. viewed Korea as a victim of Japanese occupation and not an ally that required conquering. There were responsibilities for which the U.S. had to own up to from agreements reached at the Cairo Conference in 1943 and the Yalta Conference of 1945. The U.S. recognized the implications and challenges to maintaining peace in an occupied Japan if a force hostile to an occupied Japan inhabited Korea. Russia's entry into the war against Japan on 9 August 1945 hastened decisions regarding terms of surrender and the fate of the Korean peninsula. Until Japan agreed to surrender, allied military planners were prepared for the eventuality of engaging the thousands of Japanese troops stationed in Korea. A Russian invasion into Korea figured prominently in those plans.

On 14 August 1945, the Japanese agreed to surrender after the U.S. dropped atomic bombs at Hiroshima and then later at Nagasaki. When the Japanese agreed to surrender, planning efforts were hastily devised to prepare for the surrender of Japanese troops in Korea. The Russians, having gained a foothold on the Korean peninsula by invading on the northeast coast near Rashin, began pouring in from maritime provinces of Siberia, down the Korean peninsula and into the Kaeong-Ch'unch'on area above Seoul where they looted equipment, including locomotives and rolling stock. Back in Washington DC, a hastily prepared General Order No. 1, which served as the terms of surrender for the Japanese, stipulated that Japanese forces north of the 38th parallel would surrender to Russian forces while those south of the parallel would surrender to the commanding general of the U.S. expeditionary forces. Considerations were discussed to draw the division at the 39th parallel, but the presence of Russian troops in Korea north of Seoul made that position untenable. The Russians were already knocking on the door of Seoul when the terms of surrender for Japan were being staffed with Moscow for concurrence. On 16 August 1945, Stalin did not disagree to the terms splitting Korea into two zones separated at the 38th parallel – but he did ask for “corrections” to some of the proposed terms of surrender.

This division did not take into account the specialization that had developed – the North was inhabited by 9,000,000 people and had the lion's share of the minerals, modern hydroelectrical power plants, and the

country's heavy industrial base – the South was largely agrarian and was inhabited by 20,000,000 people. Cultural and social differences between the northern industrialized inhabitants and southern agricultural based inhabitants of the country existed which were further exacerbated by the division of the country at the 38th parallel.

A Divided Country – Managing Chaos in the South

In his role as the Supreme Allied Commander, General Douglas MacArthur was designated by the U.S. Joint Chiefs of Staff to formally accept unconditional surrender of the Empire of Japan on 2 September 1945. However, actions were taken in the days immediately before the formal surrender ceremony in an attempt to provide stability in the regions south and to the north of the 38th parallel which were occupied by Japanese military forces. With the Japanese surrender, there was a need for allied forces to assume custody of the Korean peninsula from the Japanese military. Unlike his Russian counterparts in the North, at the outset of the occupation of South Korea, General MacArthur had minimal guidance from Washington regarding the role of U.S. forces in occupied areas. MacArthur designated the XXIV Corps, commanded by LTG John R. Hodge, to carry out the terms of surrender in Korea and to occupy and administer South Korea on behalf of the U.S. General Hodge became commander of the United States Army Forces in Korea (USAFK) on 27 August 1945. It became clear from the outset of the American occupation that there was a lack of a clear American policy and guidance. The planning priorities emphasized the establishment of post-war Japan and lacked clear guidance to effectively govern Korea. A steady and considerable rotation policy in Korea brought unqualified people into positions at all levels of responsibility in the Korean occupation. The language barrier between Koreans and the Americans also added to the confusion and fostered a distrust of the local national interpreters and Americans by the Korean people.

During the post-WWII years, the Soviets successfully molded a replica of a Stalinist communist state government in North Korea by installing communists in leadership positions friendly to the Soviet Union. By October 1945, Kim Il Sung assumed control of North Korea's Communist Party while American policy developments on Korea began to emerge. Syngman Rhee

and Kim Koo were establishing themselves as leaders of the South Koreans. The ultimate objective of the Americans for the Korean peninsula was "to foster conditions which will bring about the establishment of a free and independent nation capable of taking her place as a responsible and peaceful member of the family of nations." MacArthur was further instructed, "In all your activities you will bear in mind the policy of the U.S. in regard to Korea, which contemplates a progressive development from this initial interim period of civil affairs administration by the U.S. and the USSR, to a period of trusteeship under the U.S., the United Kingdom, China, and the USSR, and finally to the eventual independence of Korea with membership in the United Nations organization." But the Russians had a differing agenda to unite the peninsula under communist rule as a satellite nation of the Soviet Union. With the installation of a communist government in the north by February 1946, the Soviets withdrew all but 10,000 of its occupation forces. In contrast, communists inspired riots in the South in the autumn of 1946 prompted LTG Hodge to declare martial law. The South retained forces of over 43,500 U.S. soldiers and began efforts to establish a national police force and the arming and establishing of a ROK Army. By mid-1947, the U.S. State Department was directed by President Truman to take the lead away from the U.S. military in civil administration in the South. Ongoing efforts to engage in negotiations between the North and the South between the U.S. and the Soviet Union were futile in realizing the eventual reunification of the Korean peninsula under a single government.

From the outset of the post-war years, reunification efforts of the North and South were highly unsuccessful. When cooperation between the U.S. and the USSR failed after 2 years of fruitless efforts, the U.S. successfully won support for reunification of Korea through diplomatic efforts at the United Nations. A meeting in Moscow in December 1945 brought together delegations of the USSR, U.S., and Great Britain. This commission agreed that a trusteeship between the USSR and the U.S. would be formed to oversee the creation of a provisional Korean democratic government for all of Korea. After 2 years of occupation and with no solution for unification in sight, the U.S. placed the matter for consideration before the General Assembly of the United Nations on 23 September 1947. The United Nations General Assembly passed a resolution

in November 1947, which called for elections. Despite a lack of cooperation from the Russians and a lack of participation in the process by North Korea, elections were conducted in Korea that elected members of a governmental assembly in May 1948. The new assembly of the ROK convened for the first time on 31 May 1948 and elected 73-year-old Dr Syngman Rhee as its chairman. The assembly produced a constitution in July 1948 and on the 20th of the month, elected Dr Rhee President of the republic. On 15 August 1948, during elaborate ceremonies at Seoul, General MacArthur proclaimed the new ROK. Doctor Syngman Rhee was formally inaugurated as President, and USAFK's governmental authority came to an end. The U.S. formally recognized the ROK on 1 January 1949 and appointed John J. Muccio as the first U.S. ambassador on 21 March 1949.

With a duly elected government in place in South Korea, attentions turned towards a withdrawal of American troops from Korea. By 15 September 1948, American forces began withdrawing from the peninsula. Despite predictions that the South Koreans would be unable to hold their own if invaded by the North, full withdrawal of all forces was accomplished by June 1949. It was believed that promises from the U.S. to provide economic aid to the ROK along with U.S. military advisors and military equipment for its Army and national police force would be sufficient to deter aggression by the North. The ROK forces by 1 March 1949 totaled about 114,000, including a 65,000-man Army, 45,000 police, and a coast guard of 4,000. When the U.S. agreed in March to support a Korean Army of 65,000 men, the ROK moved forward rapidly, and within 5 months, recruited nearly 100,000 men for the new Army. This new Army was needed to counter the ever-growing threat in North Korea, which did everything in its power to overthrow the government in South Korea from the outset of its establishment. South Korean armed forces were equipped and organized as a constabulary force. They had only light weapons, no air or naval forces, and were lacking in tanks, artillery, and many other essentials. The decision to equip and organize them in this manner had been made by the State Department. Efforts to overthrow the South Korean government included the usage of propaganda, terrorism, guerilla warfare, and rioting in occupied areas. By 1950, the Korean peninsula was firmly entrenched in established diametrical ideologies and

governments in the North and the South – each armed and supported by a superpower and bitterly divided about how best to reunite the nation. In January 1950, Secretary of State Dean Acheson gave a speech excluding South Korea from the “defensive perimeter” of East Asia. South Korea’s forces numbered 100,000 U.S. trained constabulary troops, with few weapons besides their rifles and were opposed by a Soviet trained North Korean Army of 200,000 men equipped with every modern adjunct of war. In June 1950, North Korean troops crossed the 38th parallel and invaded the ROK. Within 3 days, Seoul, the Capitol City of South Korea, was captured. This ambiguity in U.S. policy toward Korea is believed to have invited the attack.

Conclusions

The Korean peninsula has historically been victimized because of its own geography and its proximity to three major world powers. It occupies a strategically significant position, which historically invited its stronger neighboring superpowers to exploit its resources, land, and people for their own self-interests. Following WWII, American planners and policy-makers failed to foresee the problems the world would encounter by dividing countries and forming trusteeships among the allies. The U.S. policy-makers were slow to recognize the importance of the East. This lack of foresight provided the Soviet Union, the world’s only other superpower, with a head start in exercising its traditional practice of exploiting the Korean peninsula. Policy-makers in Washington DC failed to provide clear guidance and direction immediately following the occupation of Korea by the U.S. The Americans withdrew from Korea leaving a lightly armed military that was outnumbered to defend the ROK against a superior military force in the North. As Fehrenbach states in his classic about the Korean War entitled, *This Kind of War*, “a war is made when a nation or group of nations is frustrated in its political aims or when ends can be achieved in no other way.” Fehrenbach further states, “a war is made when a government believes that only through war, and at no serious risk to itself, it may gain its ends.”

More recently, Michael Barone’s comments in a recent article appearing in U.S. News and World Report about foreign policy with China indicates, “the lesson is clear. If you know you’re going to have to defend an ally from attack – as President Truman quickly realized – then let

everyone know in advance. Ambiguity doesn’t mollify; it invites attack.” The presence of U.S. and United Nations Forces in Korea serves as an unambiguous signal to North Korea and serves to reinforce our commitment to peace and stability on the peninsula. For the past 50 years, the U.S. and the ROK have maintained a close relationship. In the 50 years since the beginning of the Korean War, there exists a sharp contrast between North and South Korea. Three decades ago, South Korea’s Gross Domestic Product (GDP) per capita was comparable with levels in the poorer countries of Africa and Asia. Today, its GDP per capita is eight times India’s, 15 times North Korea’s, and already up with the lesser economies of the European Union. As we embark upon the 50th anniversary of the invasion of the ROK by North Korean forces in June 1950, there is some hope that some day the peninsula will be peacefully reunited. It is likely that until that happens, a continued U.S. presence must be maintained. With that presence, there remains an all-important mission for military medicine to conserve the fighting strength and to protect the forces that reside on the Korean peninsula.

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18th MEDCOM Facilitates High Quality Care in Korean Hospital

MAJ Scott W. Childers, MS+

A significant step in improving relations with Korean medical facilities occurred recently at the Headquarters of 18th Medical Command (MEDCOM), Seoul Korea: the signing of the first Memorandum of Understanding (MOU) with a Korean hospital since U.S. forces have been in Korea. The MOU was signed by Colonel James Kirkpatrick, Commander, 18th MEDCOM, and Dr Chung-Ku Rhee, CEO of Dankook University Hospital located in Cheonan, near Camp Humphreys (see figure). The MOU paves the way for MEDCOM personnel to conduct periodic visits to the Dankook University Hospital to ensure high quality care is provided patients sent there by 18th MEDCOM, and to family members and civilians who choose to be seen at Dankook.



Dankook University Hospital is a familiar organization to members of C Company, 168th Medical Battalion, the unit running the Army Health Clinic at Camp Humphreys. Providers from the clinic have periodically used Dankook when patients' needs could not be met at the clinic and it wasn't feasible to send the patients to the 121st General Hospital in Seoul. Clinic personnel at Camp Humphreys established relations with personnel at Dankook to ensure quality care for their patients. The MOU will now expand that relationship to allow U.S. medical personnel to look more in depth at credentialing and other quality indicators at Dankook.

A key component of the MOU is the requirement for Dankook to use providers who can communicate with patients in English or use a translator. In the past, the language barrier has been a significant impediment to effective communications.

The MOU is not as comprehensive as many contractual arrangements in the U.S. This MOU was designed to solidify existing relations and move forward in efforts to improve access to high quality care. Dankook will not be able to file TRICARE or civilian insurance claims for patients. However, they will provide the required information and documentation that will allow patients to file their own claims expeditiously. Claims for Active Duty personnel will be settled directly with 18th MEDCOM.

The signing of the MOU does not

establish a TRICARE Extra network in Korea. Beneficiaries who are enrolled in TRICARE Prime are required to see their primary care manager before being seen in a civilian facility, except in emergencies. Beneficiaries who elect not to enroll in TRICARE Prime are automatically covered by TRICARE Standard and can be seen at local facilities without referral. However, there are higher co-pays and deductibles associated with this option.

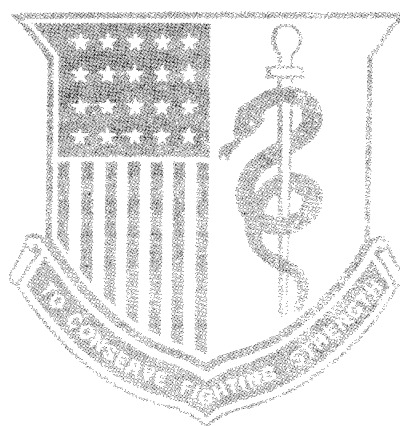
United States government civilian employees and their families, although not beneficiaries of the military health system, may choose the affiliated hospitals and be comforted by the fact that MEDCOM personnel have evaluated the quality of care and addressed issues like language barriers. Numerous other civilian hospitals throughout Korea are being considered for inclusion in our list of affiliated Korean hospitals. As the list of affiliated

hospitals grows, an updated list of facilities will be maintained on the 18th MEDCOM Web Page located at www.seoul.amedd.army.mil/index.htm. Within the Web Page will be fact sheets about the facilities, to include points of contact and phone numbers. Additional links will direct the viewer's browser to strip maps to the Korean hospitals.

This first MOU with Dankook is an important first step to improving access to quality civilian healthcare to U.S. personnel in Korea. As the list of affiliated hospitals grows, patients and providers will have more options when selecting the best course of action for their health.

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18th MEDCOM's Ambulatory Care Directorate

MAJ Scott W. Childers, MS†

The Ambulatory Care Directorate (ACD), HQ, 18th Medical Command (MEDCOM), is a newly formed organization that brings together a variety of specialists under the guidance of one senior leader. Its purpose is to synergize the effectiveness of the individual components in an effort to enhance readiness and facilitate efficient and effective quality healthcare in an armistice environment.

The ACD became an official Directorate on 1 Apr 99 with the approval of 18th MEDCOM Policy Memorandum 25. The Directorate advises the Commander on all aspects of Level I and II care required for accomplishing the armistice and transition to hostilities missions. The ACD is also responsible to develop, prepare, and sustain a Joint Commission on Accreditation of Healthcare Organization (JCAHO) accredited patient-focused integrated healthcare network in the Republic of Korea. In addition, the Directorate supports all clinical staff with education and training. Guiding principles include the continuous consideration of cost, quality, and access to care.

In order to execute its broad scope of responsibilities, the ACD consists of the staff activities depicted in the table.

| | |
|-----------------------------------------------|--------------------------------------------|
| Chief Nurse, 18th MEDCOM | Director, Managed Care/TRICARE |
| Director of Pharmacy Activities | Director of Physician Assistant Activities |
| Director of PAD Activities/Medical Regulating | Director of Clinical Education Activities |
| Senior Laboratory NCO | Senior Clinical NCO |

ACD Components

The Director of the ACD is a branch immaterial position, which will usually be filled by the senior officer assigned to the Directorate. Currently, the Director is also the 18th MEDCOM Chief Nurse. The Chief Nurse fills a vital leadership position for ambulatory care issues throughout Korea. She is responsible for nursing scope of practice and standards of professional practice as well as the management of assignments for Army Nurse Corps officers assigned to Korea.

The Director of Managed Care defines policy for Managed Care issues in Korea, and provides oversight for Managed Care processes within all military treatment facilities operating in the Eighth U.S. Army (EUSA). The Director of Managed Care is also the officer in charge of the TRICARE Service Center located in Seoul.

TRICARE is still relatively new to Korea and is still in its developmental stages. Maturation of the TRICARE program in Korea is hampered by the fact that Korea has no supporting contractor to enhance services that 18th MEDCOM has difficulty executing. This is particularly significant since the 18th MEDCOM is a table of organization and equipment unit with only limited Augmentation tables of distribution and allowances staff available. The major impact of not having a supporting contractor is the fact that a TRICARE Extra network has not been established. The current Director of Managed Care and his staff, are actively interacting with Korean medical organizations to formalize relationships that will lead to new and improved processes for ensuing high quality care

is provided to U.S. beneficiaries who are treated in Korean facilities.

The Director of Pharmacy Activities serves as the Consultant to the Commander regarding Pharmacy related issues and provides guidance and oversight of pharmacy operations in all EUSA healthcare facilities. By working with the other medical professionals, he ensures accessible, quality pharmaceutical care throughout the Command by providing consultant services, formulating policy guidance, serving as an advisor to the Pharmacy and Therapeutics Committee, and implementing guidance approved by the Commander. The Director of Pharmacy Activities also coordinates directly with the Deputy Chief of Staff, Personnel, on the assignment and utilization of pharmacy officers and enlisted pharmacy personnel.

The Director of Physicians Assistant (PA) Activities serves as the Consultant on PA issues including scope of practice and credentialing. He also provides clinical oversight for the Anthrax Vaccination Implementation Program. Statistics regarding the status of anthrax inoculations of arriving personnel are relayed back to the soldier's losing installations as a measure of the installation success, or indicator of a need for improvement. The Director of PA Activities also manages PA staffing throughout the Korean peninsula, along with managing and coordinating continuing education for PAs.

The Director of Patient Administration Activities/Medical Regulating Officer (PAD/MRO) is a multifaceted staff component within the ACD. This office provides guidance relating to patient administration functions to members of 18th MEDCOM and subordinate units. The 18th MEDCOM's PAD/MRO Director maintains close contact with Office of The Surgeon General and U.S. Army MEDCOM Patient Administration Consultants on a variety of patient administration issues facing this command and the U.S. Army at large. Currently, the PAD Consultant and his staff are working closely with subordinate units to increase Ambulatory Data System awareness and compliance. The PAD office is also in the planning stages with U.S. Army MEDCOM to deploy the automated system known as Third Party Outpatient Collections System – Next Generation (TPOCS-NG). Training and development of TPOCS-NG is slated for February 2000.

The Director of Patient Administration Activities is dual – slotted as the MRO for U.S. forces in Korea. As such, he is responsible for the Joint Patient Movement Requirements Center (JPMRC). During armistice, JPMRC is intimately involved in the development of war plans/policies and the preparation/execution of joint training exercises. The JPMRC's contingency staff consists of patient regulators from all services within Department of Defense. The JPMRC is also working on the development and deployment of TRANSCOM Regulating and Command/Control Evacuation System (TRAC2ES), and will be participating in TRAC2ES Alpha III Training and Evaluation.

The Clinical Education Division (CED) serves as the medical education link to all units on the peninsula. The CED provides a wide array of programs and courses designed to ensure that all clinical staff have the latest information regarding their area of expertise. They also coordinate to ensure that continuing medical education requirements are met in order to maintain licensure and certification.

Some of the courses that CED offers include: emergency medical treatment, combat lifesaver, Basic Life Support (BLS), Advanced Cardiac Life Support, Pediatric Advanced Life Support, Neonatal Resuscitative Program, BLS Instructor, and others. The CED recently conducted an Advanced Basic Trauma Life Support Course, which hosted 11 instructors from the Defense Medical Readiness Training Institute in San Antonio, Tx. This was the first time this course has been taught in Korea. The CED is currently working on the Annual Health Education Conference for Korea. This year's conference is titled *2000 and Beyond, Military Medicine in the Republic of Korea*.

The Senior Laboratory Noncommissioned Officer (NCO) serves as a key resource regarding the functioning of the U.S. Army medical laboratories in Korea. The Senior Laboratory NCO provides technical and administrative support to the 18th MEDCOM Pathology Consultant. He also monitors outlying clinical laboratories for compliance with JCAHO and College of American Pathologists accreditation standards. The Senior Laboratory NCO serves as an advisor to all 91K personnel in Korea assisting with training, advancement

and career progression, and assignments.

The 18th MEDCOM Chief Clinical NCO provides oversight on the training and utilization of enlisted (91C, 91B, and 91D) soldiers. The Chief Clinical NCO also serves on teams that provide guidance regarding compliance with scope of practices and JCAHO standards in ambulatory care settings throughout the peninsula.

The ACD is an important part of the 18th MEDCOM. Its unique structure and focus are proving to

be critical for JCAHO preparations for Korean military treatment facilities and in the continuous process of improving in the armistice healthcare and transition-to-war missions. The ACD is still very young and will no doubt continue to evolve to meet current and future operational requirements.

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WHNS for Medical Forces in the ROK

MAJ Mickie D. Smith, MS†

Forward-deployed forces are a key component of U.S. national security strategy and help to ensure regional stability and prevent crisis from escalating into conflict. For close to a century, the U.S. military has relied upon access to forward air bases, ports, and logistics facilities. Our continued access to these facilities depends on the political goodwill of the host nations. Commonly referred to as Host Nation Support (HNS), the access of facilities has been expanded to include provisions of manpower, equipment, and supplies/services. Wartime Host Nation Support (WHNS), however, is a force enabler critical for the execution of theater strategy. In war and peacetime, its availability provides a key link in the logistics chain and reduction of overseas basing assets has made WHNS availability more critical.

The U.S. normally will first need to deploy a large contingent of supporting forces to handle the deployment of combat forces in a major conflict. The speed in which the U.S. deploys combat forces directly affects the outcome of a conflict. The HNS agreements will facilitate the deployment of our fighting forces. The U.S. Department of Defense defines the broad concept of HNS as: "NATO Civil and military assistance rendered in peace, crisis, and war by a host nation to allied forces and NATO organizations which are located on or in transit through the host nation's territory. The basis of such assistance is commitments arising from the NATO Alliance or from bilateral or multilateral agreements concluded between the host nation, NATO organizations and (the) nation(s) having forces operating on the host nation's territory."

The key issues in this article are the considerations that must be taken into account to ensure that the HNS is available in the right type, amount and quality, and when required for our medical units. Supporting U.S. forces on the Korean peninsula is a challenge. Our efforts in identifying what we need in the way of support from the Republic of Korea (ROK) are critical to refining our

WHNS's submission to the Korean Ministry of National Defense (MND). The deliberate planning process must include the requirements for U.S. Forces Korea (USFK) units and active duty and reserve medical units deploying to the ROK during hostilities.

It is common knowledge that only a small portion of the troops and supplies needed to support the war plan are currently on the peninsula. In the event these plans are activated, what is not here must be flown into theater by strategic air or sealoft, where distance is a limiting factor. The pre-positioning of supplies is critical to combating this distance factor. However, no matter how many lift tons are available, those tons will be allotted to beans, bullets, and shooters. The more that is already in theater, the quicker and more decisive the command response and the lower the risk to the civilians, USFK, and ROK military forces.

Reliable international agreements that provide in-theater access are a much better alternative. This is especially true in the medical arena. The number of military personnel, their families, and other foreign nationals that must be evacuated and possibly treated by U.S. medical forces in the event of the outbreak of hostilities is estimated to far exceed the current medical capability.

WHNS Umbrella Agreement and Combined Steering Committee

The capstone document of the Korean/U.S. WHNS Program is the Umbrella Agreement. The U.S. Secretary of Defense and the ROK MND signed this agreement in 1991. The program was formally established after the ROK National Assembly ratified the agreement in 1992. The first submission of U.S. forces requirements was in 1994, and the publication of the Korean Provisional Support Plan (PSP) in 1995 was the resulting document,

which identified what resources are to be provided to U.S. forces. While the WHNS Umbrella Agreement includes many programs to assist U.S. forces, in the event of a crisis, hostility, or war, approved WHNS assets are not automatically available upon ROK mobilization. They are only available upon notification that the ROK MND has directed the appropriate ROK military and civil officials to release the planned WHNS in the Korean PSP.

The WHNS Combined Steering Committee or WCSC is a binational committee responsible for managing all matters related to the implementation of the Umbrella Agreement. The committee is co-chaired by the USFK Assistant Chief of Staff, J4, who serves as Chief U.S. Representative and the Director General, Logistics Bureau, ROK MND, who serves as the Chief ROK Representative. The committee's permanent members are the action officers assigned to the USFK WHNS and Government Relations Branches, U.S. Embassy, ROK MND Logistics Cooperation and Transportation Division, and the Ministry of Foreign Affairs and Trade. The committee meets a minimum of two times a year during armistice. During hostilities, it is established and operates continuously until the end of hostilities.

Types of Support

The two types of support provided for under the Umbrella Agreement are foreseen and unforeseen. Foreseen HNS is support that has been identified and requested during peacetime for provision in time of crisis or war. Based on negotiations between the Korean MND and the U.S. government, agreements are developed to obtain assured HNS for all programmed force requirements. Unforeseen HNS is support requested during crisis or war that was not identified, planned, or agreed upon during peacetime. Host nation assets are not unlimited, and the host nation will probably give its own population and military forces priority of support. Therefore, unforeseen requests for HNS may neither be fully fulfilled nor provided to support valid requirements.

WHNS Functional Areas

The HNS may come from host nation governments, civilians, military units, or facilities and may be broken

down by function or area support. The Korea WHNS Program is grouped into 12 functional areas (see figure) each managed by a Functional Area Proponent (FAP).

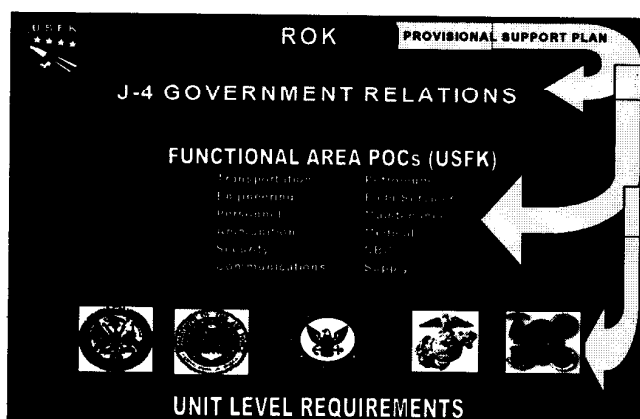


Fig. WHNS program in Korea.

During armistice, commanders at all levels conduct an analysis of their organic resources available to perform their wartime mission. Shortfalls are passed up through the chain of command. At each level in the chain, the commands attempt to resource any shortfalls. Major commands, HNS staff officers from the military services, and Major Subordinate Command Point of Contact submit a consolidated listing of all their requirements to the USFK functional area proponents. The FAPs validate the remaining requirements, deconflict requests to avoid duplication, and resource when possible. Validated unresourced requirements are then forwarded to the USFK WHNS Branch, where the data is entered into the WHNS Database. The data is then compiled into a consolidated requirement package and presented to the ROK MND for sourcing. The MND Logistics Cooperation and Transportation Division reviews asset capability in military, government, and private resources, establishes the provisional support plan, and provides the plan to USFK. This information is then passed back through the FAPs to the requesters for incorporation into their operations plans. The foreseen cycle takes 2 years to complete.

Deliberate Planning

Logistics planners typically use the deliberate planning method to identify requirements and make decisions on sourcing shortfalls. Utilizing this method,

planners should answer the following questions: Where are we on the battlefield? Why are we here? How do we support from here? How do we get support from here? When, where, and in what sequence do we displace to ensure continuous operations? To answer these questions, logistics planners conduct mission analysis with a focus on customer needs. In short, five areas that must be addressed are requirement, capability, shortfall, analysis, and solution. The level of detail that the above questions can be answered is dependent upon the planner's position in an organization. Requirements can be determined from statistical tools, historical data, field manuals, and other such material. A unit's capabilities can be gleaned from careful examination of unit resources based upon modification table of organization and equipment's, common table of allowances, etc. Finally, by comparing requirements against capabilities, logistics planners should be able to determine shortfalls, conduct an analysis, and plan accordingly.

Through the deliberate planning process, shortfalls are identified and validated for accuracy. A determination is made if WHNS is feasible to satisfy the shortfalls by analyzing the acceptable risk that can be taken for each asset. Where WHNS is not feasible, alternatives are sought to satisfy the requirement. If WHNS is determined to be an acceptable risk, the shortfalls become potential WHNS requirements and are forwarded for coordination, approval, or disapproval.

WHNS Technical Arrangements and Other Considerations

The WHNS Umbrella agreement only establishes the legal basis between the U.S. and the Korean government for moving ahead on the detailed agreements to achieve HNS. It also provides the political emphasis within the host nation to ensure that the various national agencies plan and provide the needed support. However, the next level of documentation, *the technical agreements*, addresses the major considerations and broad function areas and includes the definitions, responsibilities, procedures, etc, to provide guidance to the units for detailed HNS planning. The following table outlines some of the major considerations for planning HNS in the ROK.

| ITEM | CONSIDERATIONS |
|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Local Labor | Life Support for KSC Method and amount of payment for service Staffing and Administration when using host nation medical facilities |
| Communications | Security during contingency operations Interpreters, language specialists, and translation services |
| Transportation and Maintenance | Use of host nation military vehicles, equipment, ships, aircraft Maintenance of locally hired or commercial vehicles and equipment Policies on drivers and handlers for vehicles and equipment Evacuation of disabled vehicles and equipment |
| Movements | Commander in Chief Priorities Personnel, equipment, and security when establishing medical facilities |
| Medical | Treatment of host nation casualties in U.S. facilities Patient Regulating and Evacuation |

Table. HNS Planning Considerations

In the medical functional area, requests are typically made for real estate (to include hardened facilities such as schools, stadiums, etc), medical supplies, material handling equipment (MHE), commercial transportation assets, and local national personnel. Each of these areas has their own special concerns that must be addressed. For example, if the U.S. must house U.S. casualties in local Korea medical facilities, what is the level of support that can be expected from each facility? How will they be fed? If professional staffing is provided, what is the level of their clinical expertise? How will the patient medical regulating function be carried out between the host nation and the U.S., and integrated into the medical patient tracking system?

Field hospitals also require large areas of land to become operational. Shortfalls for land must be identified and potential sites surveyed for suitability. In addition, requirements for land must be coordinated among the Tri-Services and the ROK government to reduce conflicts. Real estate requirements must be revalidated to ensure that the property is still available. As the Korean economy begins to recover, pre-approved commercial buildings and land may no longer be available for U.S. use, or may have been nationalized by the Korean government for their own use.

Personnel support also requires special consideration. Once mobilization is declared by the Korean government, thousands of local citizens are mobilized into what is referred to as the Korean Service Corps (KSCs). The KSCs are organized into military-type units with an organizational structure similar to the U.S. and ROK military units. Battalions of KSCs report to U.S. units to offer additional support. The KSC's must be fully integrated into all operational aspects of the medical mission to achieve maximum effectiveness. Administrative and logistical support must also be provided to include the feeding, clothing, and provisioning of this labor force, as well as providing the command and control structure that effectively utilizes their abilities. Many will in effect serve as ambulance drivers, MHE operators, and supply technicians.

Other HNS Programs

Although the WHNS Umbrella covers the majority of the needs of USFK, other programs that assist in our host nation support requirements include Wartime Critical and Pre-Planned Contingency Contracts, the Commercial Design Vehicle Program (CDVP), and Wartime Movement Program (WMP).

Wartime Critical and Pre-Planned Contingency Contracts

In the event of the outbreak of hostilities, USFK may require continued contract support in order to operate successfully. There will also be immediate requirements for supplies and services that are not currently available through means other than contractual support. To determine requirements under the pre-planned contingency contracts, planners must consider requirements that were needed and provided during peacetime, but will also be required after a transition to hostilities. Medical functions that are primary candidates for pre-planned contingency contracts include the supply of medical gases, regulated medical waste disposal, and laundry services.

Commercial Design Vehicle Program

The CDVP identifies commercial vehicles that are required by military units during wartime. These vehicles and drivers are attached to an organization for the duration

of the warfight and require preventive maintenance checks and services be performed, as do our military vehicles. Requests are submitted through appropriate channels and identify the assembly areas and locations where vehicles are to be delivered to the command. Vehicles are included in the ROK mobilization plan, which is implemented upon declaration of the ROK government mobilization order.

Wartime Movements Program

The WMP is another WHNS vehicle that allows for the one-time movement of personnel, supplies, and equipment from their armistice location to their wartime location. The WMP establishes the basis for committing transportation assets and resources to support a unit's movement requirement during a contingency. The WMP does not replace existing supply distribution plans. The transition from armistice to war requires the optimum use of transportation resources to move an increased volume of personnel and materiel. The program is intended to support existing or programmed transportation movement requirements that can be defined in enough detail during the first 30 days of contingency operations. Requests are submitted only for those requirements that exceed the unit's organic and attached capability, to include allocated host national mobilized commercial vehicles.

Summary

In the Korean Theater of Operations, WHNS is the center of gravity for the medical logistician's contribution to wartime victory, and is the means to avoid catastrophe, influence critical points, and achieve logistics miracles. Logistics planners must cooperatively arrange adequate HNS in peace, crisis, and conflict and have the responsibility to ensure that HNS agreements fulfil operational requirements and enhance the combat readiness of committed forces without reducing the combat potential of the host nation itself. The correct balance depends on complex and delicate negotiations, but adequate and timely arrangements can add significantly to the effectiveness of logistic support.

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163rd Institutes OCONUS Extension of the TRICARE Family Member Dental Plan

COL Joseph W. Donahoe, DC†

On 1 October, the TRICARE Family Member Dental Plan was extended worldwide. In Korea, preparations for the plan were carried out by the 163rd Medical Battalion (DS) headquartered in Yongsan. Months of preparation culminated in what appears to be a successful start on the Korean peninsula.

The success of the program is dependent on many factors. The most important is the close relationship that the battalion has with the civilian professional community. The 163rd's parent organization, the 18th MEDCOM, has for years maintained a system of civilian consultants. These are medical and dental practitioners who are prominent leaders of their respective Korean professional organizations. The 18th MEDCOM Consultants are an invaluable link between the Command and their civilian counterparts. The Consultant for the 163rd Medical Battalion is Dr Jung H. Yoon. Doctor Yoon is Dean Emeritus of Yonsei University College of Dentistry, and former head of the College's Department of Oral Surgery. He is prominent in Korean organized dentistry. Doctor Yoon provided the 163rd Medical Battalion with an extensive list of all practicing dentists in Korea who had American training. The list included dentists in all specialty areas.

It is fortunate that Korea's dental education system was founded largely by American Missionaries. Korean Dental Schools are modeled after those in the U.S. and maintain many exchange programs with American institutions. Doctor Yoon is a perfect example. He received his Oral Surgery training at Duke University Medical Center in Durham, NC. The most important service Dr Yoon performed for the battalion was providing access to the Korean dental care system from the top down. This is a cultural necessity in Korea. You must

work through an organization's leadership rather than contacting its rank and file members first.

Another important element to the success of the program is marketing. Marketing should be done through the highest Public Affairs Office in the military community. By using the Eighth Army Public Affairs Office in Korea, we were able to access an extensive list of community newspapers, unit newsletters, and Armed Forces Korea Radio. Through 18th MEDCOM Public Affairs, we added AFKN Television, 18th MEDCOM publications, and a very comprehensive information page on the 18th MEDCOM Website. Briefings were done throughout the peninsula at units, town hall meetings, and in-processing centers. Marketing information included details about the insurance plan and how it would be administered, and points of contact both with the insurance company and locally. Points of contact information included name, phone numbers, FAX numbers, mailing addresses, and e-mail addresses.

Next is staff information and training. Battalion Commander, COL James Hoots, held a Senior Leaders Conference in which clinic leaders from all over the Korean peninsula also learned the details of the insurance plan and its administration. After returning to their clinics, leaders did an outstanding job establishing contacts with local dentists and military community leaders. They then trained their own personnel to administer the plan from each clinic. Colonel Hoots also established a Dental Benefits Advisor Office with multilingual capabilities to oversee the plan for the entire Korean peninsula.

It is important to note that even though this insurance plan is nearly identical to its CONUS version, it is administered very differently overseas. In Korea, enrolled

beneficiaries will still go to their assigned military dental clinics for treatment. The insurance plan will only be used if a covered service is not available from that clinic. For example, if a patient needed braces and there was no orthodontist assigned to their serving dental clinic, they could choose to use TRICARE Family Member Dental Plan to get the services done by a local civilian orthodontist. More information about the plan is available at each military dental treatment facility, on United Concordia Companies Website at www.ucci.com, and on the 18th MEDCOM Website at www.seoul.amedd.army.mil.

In summary, lessons learned in establishment of the TRICARE Family Member Dental Plan on the Korean peninsula include:

- Establish a systematic long-term relationship with the host nation professional community.

- Establish provider lists only with the advice and help of the senior leadership of host nation professional organization.

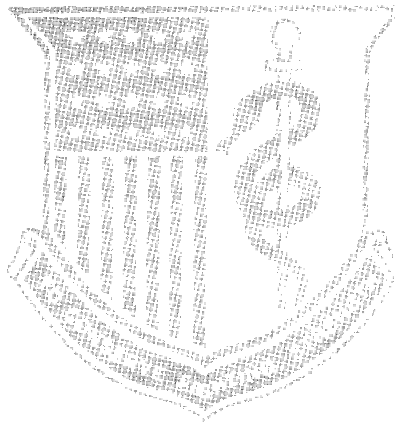
- Market the plan with the help of the highest level Public Affairs Office in the community.

- Educate and train staff personnel about the details of the insurance plan and how to administer it.

- Establish a Dental Benefits Advisor Office with multilingual capability.

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The 121st General Hospital – Leading Edge of Forward Deployed Forces

COL Tom Broyles, MS†

The 121st General Hospital, known as the 121st Evacuation Hospital until redesignated in 1994, is the Army's sole hospital serving the American forces stationed in the Republic of Korea (ROK). This forward deployed hospital serves as the primary military surgical and medical hospital in Korea. It has the dual mission of armistice healthcare in its fixed facility in Yongsan, in Seoul, and transition to hostilities healthcare using its Deployable Medical Systems (DEPMEDS) equipment. Duty in Korea is the only place in the world where American soldiers face an armed communist threat. Serving on this last "hot frontier" puts the 121st within range of 10,000 North Korean artillery systems and 2,300 multiple rocket launcher systems in North Korea's forward area of the demilitarized zone (DMZ). The most heavily armed border in the world, the DMZ lies only 35 miles north of Seoul.

The 121st came to Korea in 1950 after being constituted in February 1943 and after distinguished service in Central Europe and the Rhineland in World War II. Deployed to Korea with the X Corps as part of the historic Inchon Landing, the 121st served in nine Korean campaigns, was awarded two Meritorious Unit Commendations and the Republic of Korea Presidential Unit Citation, and has seen continuous service since the armistice in 1953.

Unlike other overseas AMEDD hospitals, the 121st is a Medical Force 2000 (MF2K) modification table of organization and equipment (MTOE) hospital that serves as the primary platform for fixed healthcare on the Korean peninsula. Serving Army personnel as well as Air Force, Navy, and Marine personnel and their family members that come to the 121st from the "Z" to the sea, the hospital has a full range of surgical and medical specialties. Over 70 providers serve the military beneficiaries in the 121st's

Yongsan hospital accredited in April 1998 by the Joint Commission on the Accreditation of Healthcare Organizations.

In its armistice role in its fixed facility in Yongsan, the 121st operates a 65-bed facility with the capability of expanding up to 152 beds. This expansion can be done using the existing physical plant in Yongsan. A special DEPMEDS table of distribution and allowances package is also available to further expand beds in Yongsan if needed.

The 121st's 476-bed MTOE DEPMEDS General Hospital is stored at Camp Humphreys near Pyongtaek, 75 km southeast of Seoul. Currently, a team of maintenance personnel supervise on going surveillance of the equipment and 121st personnel go to Humphreys to train on, maintain, and tactically load the equipment. The DEPMEDS package was originally deployed to Korea to serve as pre-positioned equipment for a combat support hospital, but the 121st was designated to receive the equipment when it was designated an MF2K general hospital. Future plans entail the establishment of a "caretaker" cadre who will provide improved maintenance of the equipment and coordinate on going training requirements. The cadre will also serve as an immediate response force to begin the deployment and establishment of the 121st's DEPMEDS in the event transition to hostilities appears imminent.

The 121st relies on Professional Filler Roster personnel from Tripler Army Medical Center (TAMC) and other U.S. Army Medical Command medical treatment facilities to bring the 121st up to full authorized strength. Augmentees from U.S. Army Reserve medical units may also provide personnel to fill critical shortages.

In Exercise Foal Eagle, conducted in the fall of 1999, the 121st exercised a 64-bed surgical hospital package drawn from all three modules of the Hospital Unit Base, the Hospital Unit Surgical, and the Hospital Unit Medical that are organic to the MF2K general hospital configuration. The 121st deployed equipment from Camp Humphreys to Camp Long, in Wongju, 120 km east of Seoul. The 121st deployed personnel from Seoul that had come from TAMC for Foal Eagle, from the 921st Field Hospital in California, and the 121st staff in Yongsan. Despite the challenges of combining personnel from three units and being forced to rely on largely nonorganic or contractor support equipment, the 121st successfully executed the deployment, establishment, and conduct of the exercise. The exercise met its objectives of conducting actual surgeries in the field, training in mass casualty situations, and conducting patient decontamination procedures.

Beyond maintaining its readiness to deploy its DEPMEDS package to the field and its on-going daily armistice healthcare mission for the Korean peninsula, the 121st has also just begun an \$86 million dollar renewal project. This enormous project will result in the

reconstruction of 60% of the existing structure and the renewal of the remaining 40%. Since the project is scheduled to last nearly 6 years, the 121st will accomplish this by shifting clinical areas around and moving administrative and support elements to temporary buildings. Limited real estate in the rapidly growing Republic of Korea seldom allows U.S. military units the opportunity of building new structures and then moving into them subsequent to construction. Operation of a facility and renewal of the same facility must occur simultaneously in the facility's existing real estate footprint.

The 121st is on the leading edge of AMEDD doctrine of focusing on MTOE hospitals performing the dual missions of daily healthcare support in armistice or peacetime and contingency medical support when required. The staff of the 121st stands ready to do both missions and to do the missions well.

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Korean War Odyssey: Return to Hill 303

CPT David Kangas, AN†

(Military medical personnel often encounter retirees and other veterans who continue to suffer physically and emotionally from the scars of battle. Some of the most traumatized veterans are those who were held as prisoners of war [POW]. One nurse discovered first-hand just how difficult the healing process can be.)

The Korean War was an unexpected conflict for the U.S., pitting the ill-equipped South Korean and the ill-prepared American forces against a well-equipped and ruthless North Korean People's Army. For the American soldiers, the easy duty of the occupation Army in Japan was shattered by a war of incredible brutality. Within days of the North Korean attack invasion, U.S. hastily deployed forces from neighboring Japan. Task Force Smith of the 24th Infantry Division was the first to arrive. They would be mauled and captured by the advancing North Koreans. The rest of the 24th Infantry Division, the 1st Cavalry Division and others, were thrown in to stem the communist tide. These early days of the conflict were filled with confusion and terror, heroism and atrocity, death and survival. Some 35 years later while stationed in Korea, CPT David Kangas (then a 2LT), heard of a little-known massacre of American soldiers during these desperate early days of the war. He became fascinated with this episode of the "Forgotten War" and slowly, over the next few years, pieced together the story of the fight for Hill 303. Due in part CPT Kangas's efforts, three survivors of the massacre received their much deserved POW Medals and on 25 July 1999, two had the opportunity to return to Korea and take part in the 49th anniversary of the Korean War. This is the story of the massacre, the search for the survivors, and their healing during the visit to Korea.

Fred Ryan, Roy Manring, and James M. Rudd are the last living survivors of the massacre at Hill 303. Privates Ryan, Manring, and Rudd received their baptism of fire as gunners in the mortar platoon, 5th Cavalry Regiment, 1st Cavalry Division. By the first week in August, their unit

had withdrawn to the south side of Hill 303 near the town of Waegwan. Waegwan was an important road junction and crossing point of the Nakdong River. Hill 303 dominated both the town and the crossing sites. Firing mortar missions around the clock, the platoon attempted to keep the North Koreans from crossing the river.

On the morning of 15 August, the North Koreans forced a crossing of the river with T-34 tanks and entered Waegwan, then turned northeast along a dirt road leading directly to the platoon position on the rear of Hill 303. Wearing captured South Korean uniforms and appearing from the rear, the North Koreans rapidly entered the American position. Within minutes they were sticking burp guns in the sides of the surprised American soldiers. The prisoners had their hands tied behind their backs with communications wire and were led down the hill to the road. They were all questioned by the North Koreans and repeatedly slapped when they feigned ignorance. Eventually they were led into one of the many ravines on the south side of Hill 303 and told they would be taken to a POW camp in Seoul. During the next 24 hours, other American prisoners were brought in, captured because they were undoubtedly caught off guard by the sudden presence of a large North Korean unit to the rear. The number eventually swelled to more than 60.

Each night, the North Koreans attempted to get their prisoners over the top of the mountain and across the river, but the American artillery had the river crossing sites under heavy pre-plotted fire. On the first night, several prisoners loosened their bindings and escaped. After the escape, the

North Koreans led away 10 American soldiers, who were last seen being beaten with shovels. When another prisoner slipped and fell on this steep hillside, the guards attacked him with entrenching tools and decapitated him.

On 17 August 1950, the 1st Cavalry Division launched a massive counterattack to recapture Hill 303 from North Koreans. Massive American airstrikes and artillery bombardment killed several hundred of the enemy. As the prisoners heard the North Korean guards exchanging fire with the advancing 1st Cavalry units, a North Korean officer gave the guards an order to shoot the prisoners. Ryan, Manning, Rudd, and two others managed to survive because they either fell or burrowed their way under the bodies of their comrades who caught the initial volley of fire. All were severely wounded. The North Koreans entered the ditch and shot anyone who appeared to be alive. After the North Koreans left the area, the survivors, with their hands still bound, managed to crawl out of the ravine and make their way toward the Americans. When the hill was retaken, 47 American bodies were found. After the war, the five survivors lost contact with each other. Ryan and Manning always thought that they were the only survivors and both began another long battle with the Veteran's Administration to prove they had been wounded in action and were POWs. In the chaos of the desperate defense of the Nakdong, their records were lost.

When CPT Kangas began to research the massacre, he found that no one knew the actual location or what became of the survivors. He began a 10-year search to locate both the survivors and the site. He traveled to the National Archives in Washington DC to review the original battle documents. He also participated in many newspaper interviews hoping that someone would recognize one of the survivor's names. In 1989, he was instrumental in erecting at Camp Carroll, Republic of Korea, a memorial for those who died in the massacre. He was also able to pinpoint the exact site, which was later visited by the Commander, 1st Cavalry Division. But he had not yet located any survivors. Finally, a breakthrough came in 1994 when a Korean War historian, who also knew Ryan, saw a newspaper interview with CPT Kangas. With the historian's help, he located the last three survivors and connected them with each other. None of the three had been awarded the POW Medal because they had not been

listed in the official POW records. After much effort, CPT Kangas persuaded the Veterans Administration to accept the battle records from the National Archives that listed both the dead and surviving soldiers as proof of their capture.

On 4 July 1994, the three survivors were presented POW Medals in an emotional ceremony at Fort Knox, KY. Five years later, CPT Kangas was again stationed in South Korea. While there, he arranged with the Korean War Veterans Association for the survivors to visit Korea. In a bittersweet visit covered by the South Korean and international media, Ryan and Manning (Rudd was unable to travel) returned to Hill 303. As the men viewed the sites of their capture and escape from death, CPT Kangas observed their evident pain and anger. Both felt guilty about surviving and they talked to their deceased comrades – trying to find peace for having lived while others died.

After several ceremonies to honor Manning and Ryan and a visit to Seoul for meetings with military dignitaries and South Korean Army veterans groups, they visited Panmunjon. At this small truce village where armistice talks are still in session, both wanted to be able to eye their executioners "face-to-face." Manning and Ryan both symbolically stepped onto North Korean soil in the armistice conference room and faced the North Korean guards. After this confrontation, a noticeable change occurred in the old soldiers. Gone from their conversation was much of the bitterness. It seemed to CPT Kangas that they had gained some internal peace and psychological healing over the horrific experiences of a half century earlier. Both said their fighting and near death in the ravine on Hill 303 was a "sacrifice that was worth it." Their faces appeared much brighter after having relived the tragedy. They agreed if needed, that they would fight again to protect South Korea.

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Garrison Medicine with a Field Medical Unit

LTC Steven W. Swann, MS†
MAJ William C. Chambers, MS††

The 168th Medical Battalion (Area Support) provides outpatient healthcare to 10 Army Camps staffed by physicians or other primary care providers. Clinical support is derived from a structure designed to provide field area medical support. This article compares garrison and combat health services, the battalion's structure, and economies of scale or scope. Further consideration is given to similar use of pre-existing healthcare assets, potential applications, and suggested criteria.

Introduction

The 168th Medical Battalion is comprised of four Medical Companies and augmented by three Preventive Medicine Detachments. The battalion provides area medical support under armistice conditions that concluded hostilities in Korea. The unit is designed for combat health support (CHS). Preparedness for transition to hostilities is a primary mission. Armistice Health Care and Transition to Hostilities are dual missions.

Armistice Healthcare Mission

The 168th Area Support Medical Battalion (ASMB) serves a combined population of soldiers, family members, retired service members and their families, Department of Defense (DOD) civilians, and other pay patient beneficiaries. The armistice mission is:

"168 ASMB will provide world-class, comprehensive, high quality preventive medicine and primary healthcare to eligible beneficiaries and communities in the battalion's area of responsibility. Preventive medicine and primary healthcare services will be available, compassionate, and appropriate. Provide urgent care services where needed. Insure all MTFs meet TRICARE Prime access standards. Medical company commanders and officers in charge will serve as installation surgeons. Provide area exercise medical support and medical training to tenant units as required."

Clinics are staffed by five Family Practice Physicians, nine General Practice Physicians, 10 Physician Assistants, and two Family Nurse Practitioners that are providing direct patient care in support of these patients. Access at nine remote clinics is 24 hours a day, 7 days a week through their Urgent Care Clinic. Preventive medical support is provided to each community by three preventive medicine detachments. Beneficiaries are listed below by clinic location:

| Military Camp | Active Duty | Total Beneficiaries |
|---------------|-------------|---------------------|
| Cp Carroll | 1,068 | 1,286 |
| Cp Edwards | 1,821 | 1,861 |
| Cp Long | 636 | 764 |
| Cp Hialeah | 617 | 976 |
| Cp Humphreys | 4,164 | 5,593 |
| Cp Page | 718 | 761 |
| Cp Red Cloud | 2,489 | 2,993 |
| Cp Stanley | 1,125 | 1,163 |
| Cp Walker | 1,772 | 2,916 |
| Yongsan | 8,588 | 8,588 |
| Grand Total | 22,998 | 26,901 |

Transition to Hostilities Mission

The 168th ASMB provides area CHS to soldiers that return to duty or evacuate to definitive medical care. Additionally, the battalion is prepared to medically support civilians that will leave Korea if hostilities occur (noncombat evacuation [NEO]). Soldiers arrive in Korea

under conditions of hostility and get similar medical support (receiving, staging, and onward movement [RSO]). Each unit in the battalion is modularly designed. Treatment teams, evacuation squads, and ancillary support are identical to CHS in the infantry. Modular design enables reconstitution of units in combat. The combat mission is:

“168 ASMB will provide preventive medicine and Level I and II CHS to NFO, RSO sites, and on an area basis in order to conserve the fighting strength; be prepared to provide reconstitution to 2ID units and deploy patient decontamination teams.”

Assets for CHS are dispersed across Korea in the communities with the soldiers and noncombatants that require daily armistice healthcare.

The 168th Medical Battalion Structure

The 168th ASMB has four medical companies, three preventive medicine detachments, and a headquarters. Each medical company has treatment, evacuation and ancillary services with x-ray, laboratory, pharmacy, dental support, and patient holding capability.

Medical companies also have administrative, training, maintenance, communication, supply, and food services. One company has additional capability for mental health services and optometry support for the entire battalion. The medical companies are the same modular design as forward support companies in the divisional structure for A, B, and C Companies. The Headquarters and Support Company is the same design as the main Support Company in the divisional structure.

Preventive medicine detachments provide entomology services, environmental science support, and closely work with veterinary services for food services and vectors of disease control.

The battalion headquarters provides personnel services, operations, plans and training, security, and logistical support. Maintenance and communications are extensively managed and supported by battalion.

Command and control of the battalion is supported by headquarters and integrated with higher headquarters.

The ASMB is made for CHS. The authorized level of organization during armistice does not provide resources for patient holding, dental treatment, or evacuation. The equipment is on hand. Soldiers from the U.S. will join the ASMB if there is a transition-to-hostilities. The time to receive, stage, onward move, and integrate the additional personnel from the U.S. is an aspect of the transition-to-hostilities mission that demands the units rehearse this professional filler system meticulously.

Economies of Scale or Scope

There are great economies of scope to provide armistice healthcare from the resources required for combat health services. Health needs of communities for ambulatory services has a close match with the capabilities and professional services in the ASMB.

Similarly, there is a match with economies of scale for provision of health services by the ASMB during armistice. The population supported is the same in peacetime as during transition to hostilities for initial planning consideration; the size is appropriate. The ASMB is in Korea to provide CHS. The ASMB is the most cost-effective means to offer peacetime health services in armistice.

Additional assets that are required to provide armistice healthcare require an operating budget of \$1,913,705 with an additional cost of \$972,000 for 30 civilian personnel. Information technology support is provided by higher headquarters. Hospitalization, tertiary services, and evacuation are also provided to the battalion from other military organizations.

Critical functions are augmented for armistice healthcare that the ASMB does not have. Resource management, clinical service support (credentialing, privileging, quality assurance, standards of practice), patient administration (appointments, diagnosis and procedure coding, billing) and fixed facility property management are provided for by the operating budget. The core added cost is for medical supplies (85%).

The commander of the battalion provides the same function as chief of the medical staff, also called the deputy commander for clinical services in military MTFs. The executive officer has the same duties as the chief executive officer, also called the deputy commander for administration. The battalion is augmented by a chief nurse to fill the role of the deputy commander for nursing. Headquarters elements provide roles and functions found in a healthcare system, a military medical activity, or a hospital. The brigade commander chairs the board of directors.

Primary care for about 25,000 beneficiaries adds about \$3,000,000 a year in variable costs. The cost per patient per year is approximately \$120. Fixed costs for the ASMB are for combat health services and are not considered in the cost of providing armistice healthcare. In fact, CHS costs are often unrelated. Heavy equipment maintenance, readiness stock rotation, soldier housing, and field training exercises are but a few of the examples of unmatched costs.

Simply put, an ASMB that is ready for combat has excess capacity under peacetime conditions. Such capacity, with marginal investment, has economies of scale and scope for armistice healthcare with minimal additional oversight cost above the armistice mission.

A Similar Use of Pre-existing Healthcare Assets

The DOD model is suited to use combat health services assets for peacetime healthcare. Federal Emergency Management Administration (FEMA) has made a similar use of civilian healthcare personnel. The FEMA trained emergency response teams are staffed from civilian hospitals or practices and are on call for crisis response. These teams are trained in the use of ruggedized medical equipment and use is similar to military reserves. Their model uses professional capacity from civilian healthcare, again with marginal investment, and has economies of scale and scope for crisis response healthcare. Clearly, military hospitals in the U.S. are increasingly integrated with collocated CHS organizations.

Potential Applications

There are potential applications for military hospitals

staffed by CHS units. If the core mission of a military hospital is to project CHS dedicated to a U.S. Army Corps or higher headquarters, the indications require a CHS structure. The CHS units have excess capacity during peacetime. Use that existing structure for peacetime healthcare instead of giving physicians to the hospital and having a cadre maintain the unit.

Examine overlapping capabilities between the peacetime healthcare mission and required combat health services units. Where there is a close match, consider use of a CHS organization to better prepare staff and leaders for assignments to deployed CHS in the future. The training benefits may be intangible but are directly related to the Army Medical Department's core mission. Once the requirement for CHS exists, the marginal costs for delivery of peacetime healthcare are a bargain compared to separate "make, buy, or contract" healthcare.

Suggested Criteria

- **Core Mission:** Examine a given healthcare provider and beneficiary population. Determine if either are required to deliver or receive CHS. If there is a requirement for integrated CHS, then criteria indicates selection of a CHS organizational structure.
- **Excess Capacity:** Examine a health delivery system and determine if there is excess capacity. If there is excess capacity to support external CHS requirements, this criteria indicates a CHS organizational structure.
- **Overlapping Capabilities:** If a military healthcare facility has overlapping capabilities with a combat health services organization structure, the criteria defaults to a CHS.
- **Training Benefits:** If there is a significant training benefit to staff and leaders in a military healthcare facility by working in a CHS unit, this criteria points to selection of a CHS organizational structure.
- **Marginal Costs:** Evaluate marginal costs related to treating beneficiaries from a CHS organizational structure versus "make, buy, or contract" healthcare delivery systems. Costs related to CHS readiness are unrelated. Do not include CHS costs in evaluation. Criteria points to a

CHS organization if the costs are equal or lower than a “make, buy, or contract” healthcare delivery system for the same beneficiaries.

Summary

The 168th ASMB is designed and deployed for combat health services. With that structure, primary and preventive medical care is provided to 25,000 beneficiaries for \$3,000,000 a year: \$120 per person per year. There are two fund sources in Korea. The cost of armistice medicine is sharply divided from CHS. Soldiers deliver primary and preventive care in armistice in this structure and are better able to provide combat health services. They work with the equipment, people, and organization every day that they would use in transition to hostilities.

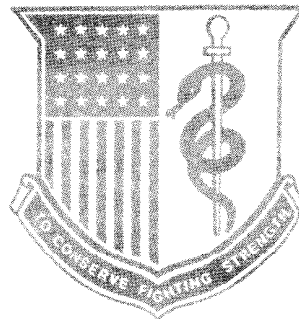
This benefit has potential for military medical activities that are not organized for CHS. The Medical

Expense and Report System’s Uniform Chart of Accounts tries to reconcile readiness costs. Our core competency is CHS; these criteria may help leaders select the best structure for the continuum of Army healthcare. Medical units reflagged as CHS units will preserve core capabilities. Our beneficiaries have been shifted away from military medical treatment to contractors that have no readiness costs or related structural costs. This may be balanced by preserving core capabilities by reflagging units as CHS units in the U.S. and using those units to deliver and project seamless worldwide, world-class healthcare.

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Protecting the Force: New Technology for Military Food Inspection

CPT Dana E. McDaniel, VC†

Military history is full of examples of food-borne illness affecting a campaign. Although there have been very few changes in operational food safety evaluation since WWI, the 106th Medical Detachment (Veterinary Service) in Korea is leading the way in selecting and field testing food safety analysis equipment. Commercial off-the-shelf technology used in the U.S. food industry is being utilized to provide commanders a risk assessment tool and provide greater safety of food products to the soldier.

All squads of the 106th inspect subsistence coming from the U.S. and subsistence procured locally.¹ They manage the Unit Basic Loads and inspect meals, ready-to-eat (MREs) for shelf life. The 106th soldiers test for surface sanitation within commissaries and in local commercial food plants. All of this is done to ensure a safe food and water supply for United States Korea service members. Within the 106th are five squads that monitor subsistence. These squads all have capabilities in performing microbiological detection on food items. Squad 3, located at Yongsan, operates the theater's only Food Safety Laboratory.² This laboratory is able to detect many of the most common organisms in food that cause disease in humans and spoilage in food.

The Food Safety Laboratory has specialized equipment to accomplish its mission, both in garrison and in the field. Among these are the Charm LUMinator T, a portable analyzer that can be used to determine quality of surface sanitation, determine shelf life on dairy products, and detect presence of pesticides in foods.³ The LUMinator T provides a luminescent assay with measurements in Relative Light Units. For surface sanitation, a specified area of a food contact surface (meat grinders, cutting boards) is swabbed with a Pocketswab.⁴ The Pocketswab is then inserted into the LUMinator T.

The LUMinator T measures the amount of bacterial adenosine triphosphate present on the food contact surface to determine if proper cleaning and sanitation has been accomplished. These diagnostic tools, which have been adapted from industry, are being used and evaluated in a field environment.

Pesticides in foods are being detected using the LUMinator T. The most common use is to determine the level of pesticide residues on fresh fruits and vegetables; the LUMinator T can also detect pesticides in beverages. The LUMinator T detects both N-methylcarbamates (CM) and organophosphates (OP). A single assay can detect the cumulative levels of all CM, OP, and their active metabolites. Technology of this type has the potential to be used for detection of some nerve agents in the future. Since many nerve agents utilize these same compounds in their formulation, the LUMinator T, or a similar device, may someday help determine when food and water have been contaminated with an agent.

Shelf life prediction (SLP) on dairy products is done using the LUMinator T. The SLP enables inspectors to verify the safety of a dairy product and often extend the shelf life of milk, ice cream, sour cream, whipped cream, and other dairy products. This provides great savings to the Department of Defense by not having to destroy these products just because they have reached their expiration date. Given proper storage conditions and handling, many items have a longer shelf life than initially stated.

In the laboratory, the 106th uses Pathogel and Petrifilm to detect microorganisms in foodstuffs.^{5,6} Fluid items can be measured and directly added to the Pathogel or Petrifilm. Solid foods, like ground beef and deli sandwiches, can be emulsified in a stomacher with a

diluent. The rinse water from this emulsification is then added to the Pathogel. The Pathogel is incubated for up to 48 hours and will detect presence of coliforms, *E. coli*, and hydrogen sulfide producing *Enterobacteriaceae*, such as *Salmonella* spp. Petrifilm is also incubated for 48 hours, and depending on which Petrifilm is being used, can detect total plate counts of aerobic bacteria, coliforms, *E. coli*, and hemorrhagic *E. coli* 0157:H7. Another Petrifilm test is used on bread products to detect yeasts and molds, such as *Aspergillus niger*, *Hansenula anomala*, and *Saccharomyces cerevisiae*.

Other tests performed in the 106th laboratory include: a phosphatase test to measure efficiency of pasteurization of milk and milk products; an enzyme-linked immunosorbent test for detection of *Listeria* spp, *E. coli* 0157:117, and Staphylococcal enterotoxins A-E; and a Rapid Colorimetric Test to determine bacterial counts on surfaces.⁷

The 106th squads throughout the peninsula use additional equipment to assist in the determination of MRE shelf life. On each MRE case is a Monitor Mark and Time Temperature Indicator Comparator. These tags darken as temperature and/or time increases. A densitometer is used to better quantify these changes and to remove some of the subjective assessment. This helps the inspector to more accurately determine the remaining MRE shelf life and decreases the amount of destructive sampling.

To insure food safety, it is often essential to determine if temperature abuse of the food has occurred. Squads throughout the 106th frequently use TempTales to verify food storage conditions over a length of time.⁸ TempTales are compact, computerized probes that measure and record temperature over a specific period of time. They can be programmed to monitor a particular temperature range to determine if temperature abuse has occurred. TempTales are frequently used in pairs on trucks transporting food items, with one probe in the open measuring the ambient temperature in the cargo box of the truck, and the other probe imbedded in the food item being transported, such as frozen or chilled meats. If the truck is turned off during transport and the temperature increases, it will be seen when the data is downloaded from the TempTale to the computer. TempTales are also

used to monitor coolers and freezers that store subsistence. They are regularly rotated through the coolers and freezers in the commissaries to detect problems in maintaining temperatures, and have been used on request by dining facilities when they are having difficulties in getting their freezers and coolers repaired. The data that is downloaded gives a graphic presentation of the data points collected; one TempTale can collect up to 2000 data points. The TempTales can be programmed to collect data at programmed intervals and not collect data until the probe has equilibrated to the environment in which it is placed.

In addition to biological contamination, the 106th also has a water chemical agent testing kit available to test for Lewisite, Mustard, Cyanide, and Nerve Agents in water. With this simple kit, each agent can be individually identified by beads that change to various colors. This kit would be particularly critical during the unit's go to war mission to ensure water is safe prior to its use.

New technologies evaluated and fielded by the 106th provide an important technological advance to the combat service support mission. The results of their efforts will be seen in the future when all Veterinary Service TOE and TDA units will be able to provide real time, accurate food safety analysis for the field commander.

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Are You Prepared for the Unexpected?

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The Korean War was a significant event that fostered the initiation of Noncombatant Evacuation Operation (NEO). It was a war in which the U.S. decided to meet force with force in Korea to take a stand against the spread of communism. Today, Korea is still the most heavily armed border in the world.

The U.S. has continued its commitment to keep the peace in Korea, stationing about 37,000 troops throughout the South Korean peninsula to deter aggression from the North. Since July 1953 when the truce was signed, the boundary where battle lines stabilized, near the 38th parallel, has never been affirmed by a treaty. Because of this, the armed forces in Korea have to prepare for the unexpected.

Korea has a number of military families, Department of Defense civilians, contractors, and U.S. citizens that reside here. Based upon this fact, the military must have a means of evacuating these personnel in the event of a crisis.

The NEO is the plan used to evacuate noncombatants (NC) from locations in a foreign nation during times of endangerment to a designated safe haven. Often, the NC will have to make sacrifices related to comfort and abandoning personal property.

Many military units throughout the country conduct NEO exercises to practice for real-world evacuations. All units in the Republic of Korea (ROK) participate in "Courageous Channel," which is a semiannual exercise that prepares NC in the event of a crisis (see figure). The U.S. Forces Korea (USFK) would establish 18 assembly points on the Korean peninsula where NC would assemble. After the NC are screened for eligibility, the military would begin procedures to evacuate to a safe destination.



Fig. Evelina B. Edwards turns in her NEO packet during "Courageous Channel."

Noncombatants are sometimes required to be prepared, with or without notice. Due to limited time of a crisis, NC should be prepared for any contingency by having an NEO kit assembled. The NEO kit should include:

- Identification Card
- Will
- Marriage License/Certificate
- Checking/Savings/Credit Cards
- Limited Supply of Personal Items
- Clothing
- Power of Attorney
- Birth Certificate
- Passport
- Vehicle Registration/Title
- Insurance Policies
- Critical Medication (30 day Supply)
- NEO Power of Attorney

- USFK Form 178-R (NEO Data Card)
- USFK Form 197-R (NC Preparedness Checklist)
- USFK Label 40 (NEO Label)
- DA Form 2402 (Exchange Tag)
- USFK Form 194 (NC Safe Arrival Note)
- DA Form 3955 (Change of Address)
- DD Form 1337 (Authorization for Emergency Pay and Allowances)
- DD Form 2461 (Authorization for Emergency Evacuation Advance and Allotment Pay for DOD Civilian Employees)
- DA Form 1701 (Inventory of Household Goods)
- DA Form 4986 (Property Inventory)
- DD Form 2585 (Repatriation Form)
- USFK Form 123-R (NC Volunteer Info)
- USFK 198-R (NC Manifest)
- DA Form 1156 (Casualty Feeder Report)

If the order is given to evacuate, NC in the ROK will be evacuated in five stages in accordance with USFK Pam 600-300-1:

- **Alert:** NC will be notified of a crisis that may require relocation or evacuation.
- **Assembly:** After notification to assemble, NC will go to their pre-established evacuation control center (ECC) or assembly site.
- **Relocation:** Relocation will be conducted to move NC from ECC to safer sites or ports of embarkation.
- **Evacuation:** Evacuation is the movement of NC from the ROK to a safe haven (often, the U.S.)
- **Repatriation:** Repatriation is where NC are assisted to their final destination.

The concept of having to evacuate is never an easy thing to grasp. Although we have honored our commitment to keep peace in Korea, we do not want to find ourselves unprepared in the event of a crisis. For this reason, the military has put NEO programs and exercises into effect to help alleviate the burden of not being prepared. When exercises are announced, take full advantage of the opportunity to ensure both you and your

family are prepared to evacuate quickly. Every family is assigned an NEO Warden (a military representative responsible for checking on their group of NC and continuously providing information). If you have any questions or concerns, contact your assigned NEO Warden.

Fictitious Scenario

The town of Panmunjom has been going through civil unrest for the past 3 months. Along the demilitarized zone, there is a crowd of over 350 demonstrators with North Korean soldiers ready to fire. Although the demonstrators have not yet crossed the line that divides the North Koreans from the South Koreans, it is extremely close. Every month, the demonstrators make their way closer and closer.

The crowd begins to yell louder and move closer. Realizing that the situation is beginning to escalate and they have now become a threat to U.S. forces, the Company Commander directs his soldiers to place their weapons at the ready and has another soldier disperse more ammunition.

A professional interpreter, who is now attached to the unit, tries to rationalize and converse with the apparent leader of the crowd. The leader, however, makes it clear that they have no intentions of leaving.

Fifteen or so demonstrators are now just a couple of inches away from the line that divides us from them. They are carrying clubs, knives, sticks, and glass bottles. The Company Commander has been constantly reporting to his higher headquarters. Without hesitation, headquarters says, "We will initiate NEO for the surrounding areas."

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Combat Medic Prayer

Oh Lord, I ask for the divine strength to meet the demands of my profession. Help me to be the finest medic, both technically and tactically. If I am called to the battlefield, give me the courage to conserve our fighting forces by providing medical care to all who are in need. If I am called to a mission of peace, give me the strength to lead by caring for those who need my assistance. Finally, Lord, help me to take care of my own spiritual, physical, and emotional needs. Teach me to trust in your presence and never-failing love.

Amen



WRITING AND SUBMITTING ARTICLES FOR THE AMEDD JOURNAL

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- 1. Manuscripts will be reviewed by the Journal's Editorial Board and, if appropriate, forwarded to the appropriate Subject Matter Expert for further assessment.*
- 2. It may be necessary to revise the format of a manuscript in order to conform to established page composition guidelines.*
- 3. Articles should be submitted in disk form (preferably Microsoft Word on 3.5" disk) accompanied by two copies of the manuscript. Journal format requires four double-spaced typewritten pages to complete one page of two-column text. Ideally, manuscripts should be no longer than **20 to 24 double-spaced pages**. Exceptions will be considered on a case-by-case basis.*
- 4. The American Medical Association Manual of Style should be followed in preparation of text and references. Abbreviations should be limited as much as possible. A list identifying abbreviations and acronyms **must** be included with the manuscript or materials will be returned to the author.*
- 5. Photographs submitted with manuscripts can be black and white or color. Color is recommended for best print reproduction quality. Space limitations allow no more than eight photographs per manuscript. Only photographic prints will be accepted for publication. Slides, negatives, or X-ray copies will not be published. Their position within the article should be clearly indicated in the manuscript. To avoid possible confusion, the top of photographs should be marked on the reverse. Photo captions should be taped to the back of photographs or submitted on a separate sheet.*
- 6. A complete list of references used in the text must be provided with the manuscript. This list should include no more than 25 individual references, if possible. Each should provide the author's last name and initials, title of the article, name of the periodical, volume and page number, year of publication, and address of the publisher.*
- 7. Drugs should be listed by their generic designations. Trade names, enclosed in brackets, can follow.*
- 8. The author's name(s), title, current unit of assignment, PCS date (if applicable), and duty phone number **must** be included on the title page.*
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